Children's Mercy
FAMILY HEALTH PARTNERS

Response to:

**Request from Lieutenant Governor Jeff Colyer, M.D.**

**Relating to Medicaid Transformation Ideas**

Presented to:

**Medicaid Reforms c/o Dr. Barbara Langner**
**Medicaid Director**
**Kansas Health Policy Authority**
**900 SW Jackson, Suite 900**
**Topeka, KS 66612**

Submitted by:
**Children's Mercy Family Health Partners**
**Robert D. Finuf, CEO**

**February 25, 2010**

## I. Introduction

Children's Mercy Family Health Partners (CMFHP) is a not-for-profit safety net health plan owned by Children's Mercy Hospital & Clinics, a not-for-profit free-standing pediatric health system based in Kansas City, Missouri. CMFHP operates an integrated care system that contracts with the States of Kansas and Missouri to provide health insurance benefits to children and adults who are eligible for Medicaid or the Children's Health Insurance Plan (CHIP).

For nearly fourteen years CMFHP has been dedicated to serving low-income families and other vulnerable populations, the providers who care for them and the advocates who assist them. CMFHP is committed to investment in the communities we serve and improving the quality, access and efficiency of health care within those communities.

Since 1995 the State of Kansas has contracted with a number of managed care organizations (MCOs) to provide Medicaid and CHIP services. Managed care is designed to create financial incentives for private health plans to provide access to appropriate care and to improve health outcomes while eliminating unnecessary services through administrative control. Currently 34 states utilize capitated managed care contracts for some portion of their Medicaid and/or CHIP populations.

In addition to the reasons stated above, states also utilize contracts with capitated MCOs in large part to achieve budget predictability which is particularly critical in tough budget situations. Further, by contracting with private companies, states are able to harness the expertise provided by those organizations without dramatically growing the size of government. KHPA has estimated that the use of the current MCOs for Medicaid and CHIP (CMFHP and Unicare Health Plan of Kansas) saves the state of Kansas an additional $10 to $15 million annually.[1] Earlier this year Missouri's Medicaid program conducted a cost analysis of its managed care program versus its fee-for-service program. That study, conducted by Mercer, found that managed care saved Missouri approximately $38 million in SY2009 (2.7%).[2]

In February 2011, there were more than 195,000 HealthWave members being served by MCOs in Kansas. Of that group, more than 68% (about 132,000) are served by the State's only not-for-profit, safety net health plan, CMFHP.[3] CMFHP has been proud to serve the state of Kansas since 2007. We prepared a document which highlights the value of capitated managed care in general and CMFHP's performance in particular and how the investment of public dollars to care for Kansas' medically vulnerable population has resulted in the following:

- **Affordability** through budget predictability and cost savings
- **Better health care access and outcomes**
- **Outstanding provider** and **customer satisfaction** results, and
- **Accountability** for **taxpayers and policymakers**

Attached as **Appendix A** is a copy of that paper titled, Medicaid Managed Care & CMFHP: A Proven Record of Providing Value. In light of the demonstrated value that CMFHP and the

[1] Minutes from the Joint Committee on Health Policy Oversight Hearing, October 16, 2006; p. 5.
[2] Managed Care Cost Avoidance Model, Missouri Department of Social Services, MO HealthNet Division; Mercer Consulting Services, January 29, 2010.
[3] KHPA Enrollment Report, February 4, 2011.

managed care model has brought to a sector of the Medicaid population (TANF and CHIP), we believe it is important that the state continue this model and look to expand it to other populations where it makes the most sense. In light of discussions in meetings with Lieutenant Governor Jeff Colyer and the Kansas Association of Health Plans, CMFHP is submitting a list of recommendations that it believes will help the State of Kansas' Medicaid Program achieve greater cost savings and efficiencies. These recommendations include proposals that:

- Focus on high cost, unmanaged populations in Kansas;
- Focus on greater administrative simplicity and efficiencies;
- Encourage the state to take a more aggressive and innovative posture with the Centers for Medicare and Medicaid Services relating to approvals of incentives that CMFHP might offer to assist in positively impacting member behavior;
- Recommend Use of Alternative Revenue Enhancements.

## II. Proposals Focusing on Kansas' High Cost, Unmanaged Populations

### A. Care Management of Aged, Blind & Disabled (ABD) Population in Sedgwick County Pilot Project

While Kansas has an extensive history using Medicaid managed care for children and families, it has traditionally not utilized a managed care model for delivering care to its high cost populations, specifically the Aged, Blind and Disabled (ABD). This aspect of Kansas' Medicaid program is not unique to Kansas. Nationally, the number of Medicaid beneficiaries in managed care has nearly doubled in the most recent decade (growing from 17.8 million as of June 30, 1999 to 33.4 million as of June 30, 2008),[4] however, managed care spending as a share of total Medicaid spending on services is low (just 20% in 2007). Many of the highest-cost Medicaid beneficiaries (i.e., the elderly and disabled) remain in the fee-for-service sector.[5] Similar statistics exist in Kansas as the aged and disabled population in Kansas accounts for 33% of the Medicaid population, but 67% of total Medicaid spending.[6] Almost half, 47%, of the growth in Medicaid from FY 2007 to FY 2009 can be attributed to the aged and disabled; 39% attributed to the disabled and 6% to the aged.

KHPA conducted a thorough program review of the growth in spending on medical services for the disabled as well as pointing out the chronic and often multiple health care needs of this population. KHPA recommended that the state move towards a model of care coordination to improve the health of the Medicaid disabled, particularly emphasizing the coordination between behavioral and physical health.[7] CMFHP proposes a care management pilot project for the ABD population (64 and younger) in Sedgwick County. A small portion of this population was managed in the Enhanced Care Management (ECM) program which was funded by KHPA from March 2006 to July 2009. CMFHP believes that it can successfully partner with the ECM program and provide additional expertise as well as an alternate funding source that would make a new pilot program in Sedgwick County more beneficial to the state and other stakeholders.

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[4] Medicaid and Managed Care: Key Data, Trends, and Issues; Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2010; pages 1-2.
[5] Id at page 2.
[6] 2009 Medicaid Transformation Program Review: Growth in Spending on Medical Services for the Disabled, Kansas Health Policy Authority.
[7] Id. at page 26.

CMFHP recognizes that a significant barrier to bringing any kind of care management model to an unmanaged population is the up front investment required. While we strongly believe there is opportunity for the state to save money, the reality is that the resources needed to generate those savings are not available through state funding. It will take a new and innovative approach to develop a new payment and delivery model for the ABD population. Last year, CMFHP and the other Medicaid Health Maintenance Organizations (HMOs) in Kansas successfully removed a privilege fee exemption which had kept these HMOs from paying more than $4 million in privilege fees on their premium revenues. Once that exemption was removed and the state reimbursed the Medicaid HMOs for the cost of that fee (currently 1% of total premium revenue), the state was able to leverage additional federal Medicaid dollars (more than $6 million). Removing this fee exemption effectively allowed CMFHP to not pass on the 10% Medicaid provider payment cut that was instituted January 1, 2010 to June 30, 2010.

CMFHP proposes using this same privilege fee mechanism as a means to generate the revenue needed to fund a pilot care management program for the ABD population in Sedgwick County. See **Appendix B** for a graphic description of this proposal. CMFHP recommends that it receive prepaid capitation payments, including the enhanced payment for the HMO Privilege Fee and the Federal Match Share for medical services and administration for ABD pilot members. CMFHP proposes to accept the same administrative fee levels now payable to the state's benefit administrator for the pilot population. There would need to be sufficient participation in the program in order to generate enough benefit from the proceeds of the HMO fee to pay for the care management function. Something in line with the Medicare Physician Group Practice demonstration project would be required, i.e. a minimum of 5,000 members. We propose that the enrollment in this program be voluntary, however in order to ensure adequate participation the enrollment should be by assignment with an opt out provision.

CMFHP, as a not-for-profit, community based organization, will partner with another community based program, that is, the Enhanced Care Management Program that was previously in place in Sedgwick County for the "on the ground" care management services needed. All other functions, i.e. health services oversight, customer service, claims payments, data collection and analytics would all be administered by CMFHP. We also propose a shared savings approach. We propose that the baseline cost and performance measures be developed and agreed upon by all stakeholders in advance. Under our proposal the state, providers (through the ECM Program) and CMFHP would share equally in any savings generated by this model. We believe it is critical to engage all stakeholders in the process if transformative and sustainable change is to occur. As the state's only not-for-profit, safety net, provider owned plan administering public program benefits, CMFHP is in a unique position to facilitate the proposed pilot.

While it is difficult to make specific cost savings projections for this population without having all of the detailed data, other analysis of care management models for the SSI and SSI-related populations have shown significant savings for their states. In Arizona, 60 percent of the $102.8 million savings achieved from 1983 to 1991 is from the SSI population. In the Kentucky Region 3 Partnership, the SSI population made up 25 to 34 percent of total enrollment and accounted for 53 to 61 percent of the savings achieved from 1999 to 2003. An analysis of a subset of the entire Oklahoma aged, blind, and disabled (ABD) population who were enrolled in a particular Medicaid health plan and who were among the highest 10 percent of service users found that overall costs per member per month (PMPM) were four percent lower in managed care than in fee-for-service (FFS). The Texas STAR+PLUS program, which focuses on SSI enrollees, achieved PMPM savings of $4 in the first waiver period and $92 in the second waiver period. In addition, Pennsylvania HealthChoices, which relies heavily on capitation for its disabled

population, experienced average annual per capita costs that were $6,800 lower for its beneficiaries with disabilities than the average of surrounding states.[8] Considering Kansas spent more than $425 million on this population in SFY 2009, any percentage of savings would be quite significant, particularly when you consider that our proposal requires no investment or additional allocation of state general funds.

### B. Pediatric Medical Home for Children with Special Health Care Needs (CSHCN) Pilot Project

Children's Mercy Hospital and Clinics (CMHC) provides care to a large number of children with complex medical conditions. Children with Special Health Care Needs (CSHCN) are those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally[9].

Such a definition includes children who receive services from up to three or more specialists, are dependent on medical technology (such as feeding tubes, tracheostomy, home ventilation, and oxygen), and/or require physical, occupational and rehabilitation services, to name a few. This includes children who are premature, children with cancer, and children with other lifelong chronic conditions or disabilities. In addition to a higher level of medical needs, these children often require special community services to promote their growth, development, education, and transition to adult living. Likewise, their families may require additional support services, such as respite care, family counseling, or genetic counseling. When additional barriers such as poverty, poor literacy, language, and/or family disruption/foster care are added to the mix, providing care becomes even more complicated.

Many CSHCN in our region and their families are not consistently receiving the higher level of access, continuity and care coordination they require. Navigating medical systems and community agencies can be overwhelming. Many caregivers report that their level of access to services and care coordination does not meet the needs of the family. Few primary care pediatric clinics in our region will assume the demands of caring for families of children with moderate to severe conditions. Care for such children is typically delivered in multiple settings, and by numerous individuals and agencies. The scope and complexity of services and lack of readily available comprehensive records make it difficult, if not impossible for most families alone to manage their children's healthcare, community support services, and medical information. For children with complex health care needs, a Medical Home is the critical support to increase access, provide continuity, deliver care, manage services, and lead efforts to improve hospital and community-based care coordination. Only then would children with medical complexities be able to overcome the existing barriers and receive the multidisciplinary care they so desperately require.

There is substantial evidence that CSHCN benefit from clinical services that are provided within a Medical Home.[10] A medical home is an approach to providing health care services in a high-quality and cost-effective manner. Individuals and their health care providers act as partners in a medical home to identify and access all the medical and non-medical services needed to achieve maximum potential.

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[8] Managed Care Cost Savings – A Synthesis of 24 Studies; The Lewin Group; July 2004, updated March 2009; pages 1-2.

[9] McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck P, Perrin J, Shonkoff J, Strickland B. A new definition of children with special health care needs. *Pediatrics,* 102(1):137–140, 1998.

[10] Cooley, W.C., and McAlister, J. (2004). Building medical homes: Improvement strategies in primary care for children with special health care needs. *Pediatrics*, 113; 1499-1605.

Key features of a Medical Home include care that is accessible, family-centered, continuous, coordinated, comprehensive, compassionate, and culturally competent.[11] While all children deserve a medical home, comprehensive and coordinated care in this setting is essential to empower families of CSHCN to manage their conditions, maintain their abilities, and promote their development.

As the premier pediatric center in the region, Children's Mercy provides specialist services to a majority of CSHCN, as well as providing primary care to a disproportionate number. CMH is the logical provider to develop a Medical Home service for CSHCN. The Pediatric Care Center (PCC), which houses primary care clinics near the Children's Mercy Hospital campus, has a single system for access and delivery of services for all patients. CSHCN and their families are managed within the general patient population where timely access is difficult to control and continuity is difficult to provide. As a result, many CSHCN have contact with providers who are unfamiliar with the patient and family. Long, complex histories have to be repeated numerous times, and data may not be readily available. Limited availability for acute care and long wait times for preventive care complicate efforts to provide timely, accessible and consistent services to CSHCN.[12] Thus, the lack of a clinic system that truly offers a Medical Home, and lack of system-wide care coordination are the primary barriers to delivery of family centered care that meets the needs of CSHCN.

A related barrier to providing family centered care within the Medical Home is lack of readily accessible, organized and comprehensive patient information. Written health records are often fragmented or unavailable. Information systems of unaffiliated hospitals, clinics and agencies rarely are capable of transferring data between their databases. Ineffective electronic data management and lack of centralized electronic documentation result in record searches that are time consuming and ineffective. Community-based emergency rooms, urgent care centers, primary care providers and health care agencies frequently lack access to up-to-date hospital data and timely, effective communication with our hospital-based specialists. Our dependence on the written record inhibits optimal delivery of patient care and may compromise patient safety in these fragile, high-risk children. Especially for children with complex medical conditions, data must be accurate, complete, current and securely retrievable at all times. The electronic database and pediatric health record are essential elements for the delivery of family-centered, individualized care within the Pediatric Medical Home.

**Medical Coordination Clinic & Medical DEN Program**

Recognizing the need to establish a model for providing individualized, family-centered primary care for regional CSHCN, Children's Mercy has developed a Pediatric Medical Home project to meet the needs of CSHCN. This project provides a forum to involve families, health care professionals, and community stakeholders in the development of medical homes for children with complex medical conditions. This project incorporates two related but distinct components: 1) Development and implementation of the Medical Coordination Clinic (**MCC**); and 2) Development of the Medical DEN program (**Medical Direction for Exceptional Needs**). The MCC will deliver clinical services for CSHCN receiving primary care at the Pediatric Care Center. It will house and maintain the medical homes of children with complex conditions, providing a higher level of access, continuity and coordination of care. The Medical DEN will provide a system-wide umbrella of support for the care of CMHC patients with complex medical conditions, while maintaining support for the MCC. This program will work to improve continuity of care, system-wide access, and communication between families and their CMHC providers/services

[11] American Academy of Pediatrics (2002). The Medical Home, *Pediatrics* 111, 184-186
[12] Survey of Families at Children's Mercy Hospital, 2007.

and community services and support agencies. The Medical DEN will facilitate coordination of care for CSHCN receiving care from multiple specialist at Children's Mercy – even if the child has a community-based primary care physician. CMHC has received funding from the Health Care Foundation of Greater Kansas (HCF) to further its development of a Pediatric Medical Home for CSHCN. Below are the three outcomes associated with that grant:

- **CSHCN and their families will experience improved access, satisfaction with care, and delivery of care;**
- **CSHCN and their families will experience improved coordination and continuity of care; and**
- **With enhancements and modifications to the CMHC electronic database and patient health record, families and providers will experience improved access, accuracy and management of patient data.**

**MCC Pilot Project Development**

The leadership of the Pediatric Medical Home for CSHCN will soon implement a pilot project, which will enable it to trial and refine its model for outpatient management of CSHCN. The Medical Home Inventory (provider and family versions), Family satisfaction survey and Family Quality of Life survey will be used to measure effectiveness at the beginning of the formal pilot and at the end of the HCF grant period (approximately 4-6 months). This information will be used to create recommendations for future clinic design and expansion. Enrollment will be expanded as clinic development and resources allow.

Below is a list of other targets the project team has reached regarding the MCC Pilot Project implementation:

- Developed a preliminary practice design for the MCC and created a "blueprint" (outline) for implementation.
- Established a pool of Pediatric Care Center (PCC) Attending Physicians to provide patient care and guide clinical development.
- Established the Medical Coordination Team **(MCTeam)** consisting of the LPN Clinical Services Coordinator (CSC), Social worker, and Care Coordinators (Pediatric Nurse Practitioners). This team will work with the patient's primary care provider to optimize the efficiency and effectiveness of outpatient clinical encounters. Services will be delivered by the MCTeam until the MCC is a viable clinic.
- Established a pool of PCC support staff to support the MCTeam. An education and training series is being developed to improve their proficiency and comfort with caring for children with complex conditions.
- Established the Med Complex appointment template that will be used to schedule and track MCC clinic encounters.
- Referral protocols have been developed to offer services to eligible PCC patients and to better estimate the total number of patients who could benefit from services by the MCTeam. This data will be used to define team production capacity and demand for services.
- Developing specific patient health record and electronic database (PHRED) modifications and enhancements, and other electronic resources.
- Collaborating with CMHC Information Systems dept (IS), we are developing an electronic database utility (Powerform), which will capture specific patient information and organize this data in a specific area in the health record. This data is not discretely captured presently and

makes it difficult for providers to access key information needed to care effectively for CSHCN. Critical data will be organized to make documentation, review, and reuse more efficient. We anticipate implementation of this powerform late summer 2010.

- Collaborating with CMHC Medical Information Technology dept (MIT) to create a comprehensive PowerNote. The powernote is a Cerner documentation product that will document clinical encounters, generate specific reports, and update the patient's health record.

CMFHP proposes a pilot project with KHPA for CSHCN that are not currently covered by a Medicaid MCO, such as children covered by the SSI (Supplemental Security Income) program. See **Appendix C** for a diagram of the proposed pilot. The pilot would be targeted in the metro Kansas City area. CMFHP and CMHC have looked at data for this population currently covered by Missouri's fee-for-service program and assembled costs borne by CMHC. We are currently exploring what other costs exist for this population outside the care they receive from CMHC. We would suggest a similar course with KHPA, essentially building on the current MCC Pilot at CMHC. Similar care coordination and care management activities can produce savings. While savings can vary greatly (from 0.5% to 20%)[13], nearly all studies of managed care models demonstrate a savings to the state. CMFHP proposes to use the same payment and shared savings model as described in Section II.A above for this pilot. As discussed in Section II.A above, we believe there would be opportunity to fund some of the care management activities of this population with federal match from the HMO Privilege Fee Assessment.

## III. Administrative Simplicity & Efficiencies

CMFHP recommends the state look for means of savings by promoting administrative simplicity within its public programs. We believe that there are opportunities in which the state can be more assertive with CMS when it comes to regulatory oversight of its public programs, particularly with regard to processes that have been approved in other states. We know that a number of governors have recently requested more flexibility in the management of their Medicaid programs and we would certainly encourage that approach.

Below are some examples of the types of savings that CMFHP has identified that not only produce savings to the state but also create more administrative simplicity for the state and CMFHP. While the savings for these individual items is not significant, we believe the overall philosophy of pushing for more flexibility on issues, particularly where regulations are silent is a change we would encourage with the state.

### A. Member Handbooks

Our contract with the state of Kansas requires that all members receive a printed handbook annually. Federal regulations provide some flexibility on this point and we do not believe such a requirement is explicit within CMS regulations. In fact, we are not required to do the same in Missouri. Eliminating this requirement would save approximately **$45,000** a year.

### B. Provider Directories

Another similar issue exists with provider directories. Currently we are required to include provider directories in the new member 'choice' packets. The states

[13] Managed Care Cost Savings – A Synthesis of 24 Studies; The Lewin Group; July 2004, updated March 2009; pages 1-2.

have pushed back on CMS through the Managed Care Technical Assistance Group (TAG) and CMS does appear to be reviewing this policy. CMFHP believes that providing hardcopy provider directories to new enrollees is an antiquated concept. Online provider directories are a much better way to communicate as they can be updated much more efficiently and effectively. We estimate the state could save more than **$234,000 annually** in postage costs and that CMFHP could save more than **$65,000 annually** for production costs if this requirement were eliminated. Of course we want information to be readily available, but we believe that it is via online resources and through our customer service center.

### C. CAHPS and the Children with Chronic Conditions (CCC) Population

CMFHP recommends the elimination of the requirement to conduct the CCC survey in the state of Kansas for HW 19 and HW 21. Elimination of this requirement would save **$22,000** annually. The CCC survey has 35 additional questions, resulting in a survey twice as long. This may contribute to a lower response rate. The industry standard according to our contracted third party survey organization (The Meyers Group) is that for other Medicaid clients, they do not require a separate survey for the CCC population. In addition, this is a duplication of efforts as these members could be included in the HW 19 or HW 21 survey. We have also found that the results from the CCC population do not differ significantly from the general population; therefore, not providing any information that would not be identified through the regular survey.

## IV. Use Incentives to Modify and Alter Member Behavior

CMFHP is limited as to the types and amounts of incentives it can provide to its members to encourage healthy behavior. Our current contract only permits us to use nominal incentives, i.e. any gifts or free services to beneficiaries cannot exceed $10 per item and $50 annually. However, we believe there is guidance from the federal government that allows health plans to be creative in the types of member incentives it uses. For example, the Office of the Inspector General at the U.S. Department of Health and Human Services states that it would allow **incentives to promote the delivery of preventive care**, such as pre-natal or post-natal well-baby services or are services described in the Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force.[14] Such incentives may not be in the form of cash or cash equivalents and may not be disproportionate to the value of the preventive care provided. CMFHP has been working with KHPA on being able to offer alternative types of incentives which might be more meaningful to members and therefore, encourage better preventive care and higher quality outcomes. We are encouraged by KHPA's support in this regard and we hope that it continues moving forward.

For example, some of the incentives that we are exploring are using raffles with higher dollar amount prizes to encourage adolescents to receive a well care exams annually. If an adolescent member sees his or her PCP, that member is entered into a raffle to win a Wii system. CMFHP is also exploring similar incentives to institute with pregnant members to promote better adherence to pre-natal visits.

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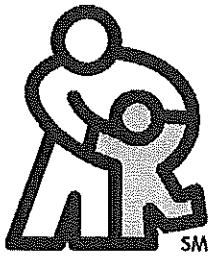
[14] Special Advisory Bulletin, *Offering Gifts and Other Inducements to Beneficiaries*; Office of Inspector General, U.S. Department of Health & Human Services, August 2002.

## V. Using Alternative Revenue Enhancements

In Section II.A and Section II.B we discussed the use of the HMO privilege fee as a mechanism to leverage additional federal funds for pilots in unmanaged high cost populations currently covered by Medicaid fee for service. CMFHP was a proponent of removing the fee exemption to Medicaid HMOs to create a level playing field among all HMOs in the state. We believe it would be appropriate to further level the playing field for all types of organizations providing health insurance in Kansas by eliminating the 1% privilege fee altogether and subjecting HMOs to the already existing 2% premium tax currently paid by insurers in the state. We understand that the 1% privilege fee was set apart from the 2% premium tax charged to all Kansas insurance companies as a means of encouraging HMO development in the state many years ago. However, it would seem that such an inequity between insurance companies and HMOs in the state need no longer exist. This leveling of the playing field would seem particularly important in anticipation of the possible future development of a state-based insurance exchange.

Further, eliminating the 1% privilege fee and uniformly subjecting HMOs and insurers to the 2% premium tax not only doubles the amount of funds that the state can leverage via the Medicaid HMOs, it also creates even more opportunity for increased revenue as federal health reform implementation progresses. The Medicaid expansion will greatly increase the amount of Medicaid HMO premium revenue generated in Kansas, which leverages more federal matching dollars. The tax paid by the HMOs generates a sizable federal match which could be used to support other state programs.

Appendix A



Children's Mercy
FAMILY HEALTH PARTNERS

# Medicaid Managed Care & CMFHP: A Proven Record of Providing Value

Prepared by:
Bob Finuf, CEO
Children's Mercy Family Health Partners

Date Originally Submitted:
January 4, 2010

Date Revised:
October 28, 2010

## I. Introduction

Since 1995 the State of Kansas has contracted with a number of managed care organizations (MCOs) to provide Medicaid and Children's Health Insurance Plan (CHIP) services. According to the Kansas Health Policy Authority, managed care is designed to create financial incentives for private health plans to provide access to appropriate care and to improve health outcomes while eliminating unnecessary services through administrative control.[1] Currently 34 states utilize capitated managed care contracts for some portion of their Medicaid and/or CHIP populations.

In addition to the reasons stated above, states also utilize contracts with capitated MCOs in large part to achieve budget predictability which is particularly critical in tough budget situations. Further, by contracting with private companies, states are able to harness the expertise provided by those organizations without dramatically growing the size of government.

As part of the state's most recent competitive bidding process, completed in 2006, it moved a large portion of its HealthWave population to the capitated MCO model by transferring approximately 50,000 beneficiaries[2] from the HealthConnect Kansas (HCK) fee-for-service (FFS), non capitated, program. KHPA awarded contracts to two MCOs, Children's Mercy Family Health Partners (CMFHP) and Unicare Health Plan of Kansas. Previously, one MCO, FirstGuard Health Plan was the only statewide MCO, and the remainder of the families and CHIP population was enrolled via HCK. KHPA estimated that by awarding the two MCOs these contracts it would save the state of Kansas an additional $10 to $15 million annually.[3]

In October 2010, there were more than 174,000 HealthWave members being served by MCOs in Kansas. Of that group, more than 68% (about 118,000) are served by the State's only not-for-profit, safety net health plan, CMFHP.[4]

This document highlights the value of capitated managed care in general and CMFHP's performance in particular and how the investment of public dollars to care for Kansas' medically vulnerable population has resulted in the following:

- **Affordability** through budget predictability and cost savings
- **Better health care access and outcomes**
- **Outstanding provider** and **customer satisfaction** results, and
- **Accountability** for **taxpayers and policymakers**.

## II. Affordability: Cost Savings and Budget Predictability

States utilize contracts with capitated MCOs in large part to achieve budget predictability and utilize other cost containment mechanisms, which is particularly critical during tough budget sessions. A Lewin Group report in 2009 synthesized cost savings reports from 24 states which had implemented Medicaid managed care programs.

The studies present compelling evidence that Medicaid managed care programs yield savings. The studies **strongly suggest that the Medicaid managed care model typically yields cost savings.** While percentage savings varied widely (from half of 1

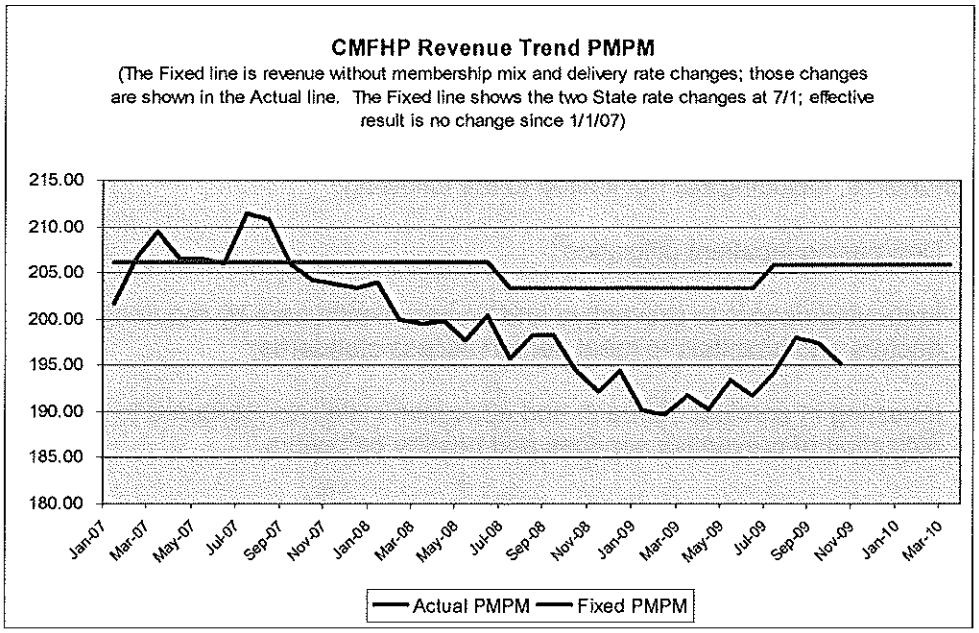
percent to 20 percent), nearly all the studies demonstrated a savings from the managed care setting.[5]

Savings opportunities in Medicaid managed care are largely created by the inherent structural challenges of coordinating care and containing costs in the FFS setting. Medicaid managed care plans have opportunities to achieve savings through a number of mechanisms, including but not limited to the following:

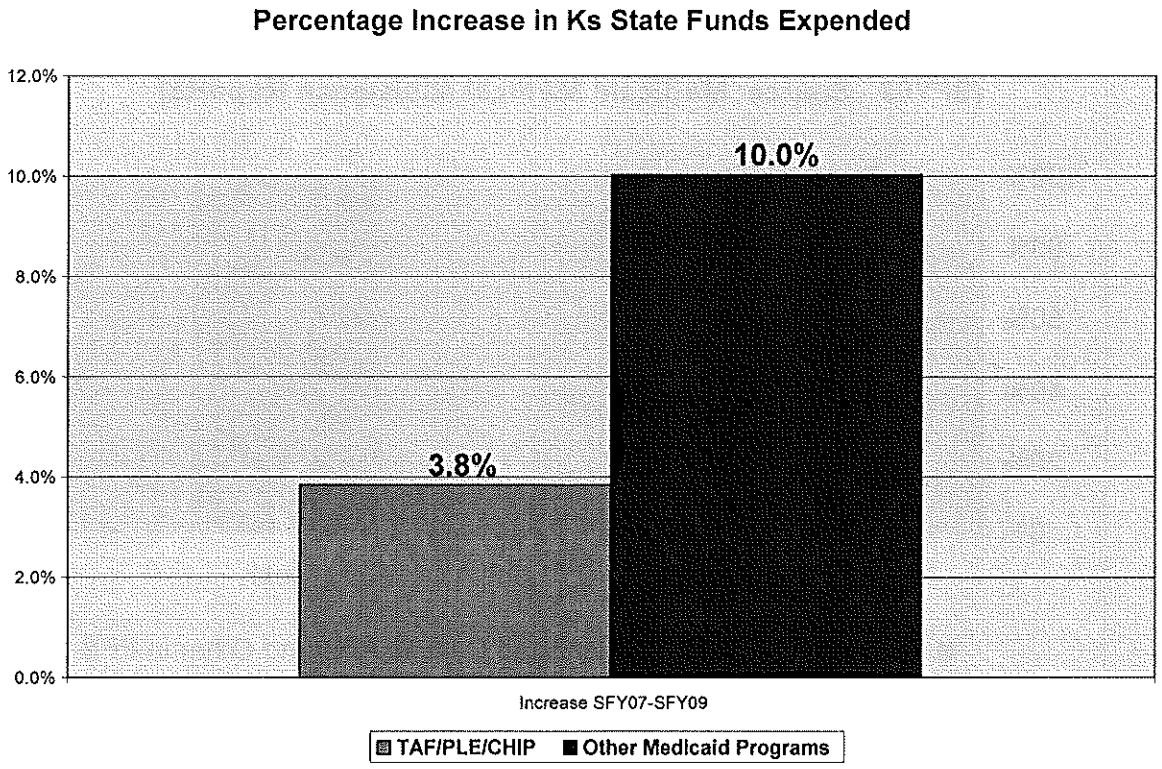
- Decreasing inpatient utilization[6]
- Improving access to preventive and primary health care by requiring participating doctors and hospitals to meet certain access standards;[7]
- Investing in enrollee outreach and education initiatives designed to promote utilization of preventive services and healthy behaviors;[8]
- Providing a "medical home" to members and utilizing a physician's expertise to refer patients to the appropriate place in the system (as opposed to relying on the patient's ability to self-refer appropriately);[9]
- Providing individualized care management, disease management and health improvement services;[10]
- Using lower cost services and products where such services and products are available and clinically appropriate (in lieu of higher-cost alternatives);[11] and
- Conducting provider profiling and enhancing provider accountability for quality and cost-effectiveness.[12]

CMFHP also contracts with the State of Missouri's Medicaid program, known as MO HealthNet. MO HealthNet and the Missouri Medicaid MCOs recently collaborated on a study relating to the effectiveness of managed care in the areas of quality, access and cost savings. The cost value study, conducted by an independent actuarial firm (Mercer), found that found that managed care saved Missouri approximately $38 million in SY2009 (2.7%).[13]

As mentioned earlier, KHPA estimated that it would save $10 to $15 million annually at the start of the current contract cycle for the two MCOs participating in Kansas HealthWave, which began January 1, 2007. In light of the tough budget situation the state has dealt with since 2008, cost savings and budget predictability should be strong considerations when evaluating the value and effectiveness of any program which utilizes state and federal taxpayer dollars. To that end, CMFHP has provided Kansas with a fixed and level capitation expense trend since January 1, 2007. See graph below.



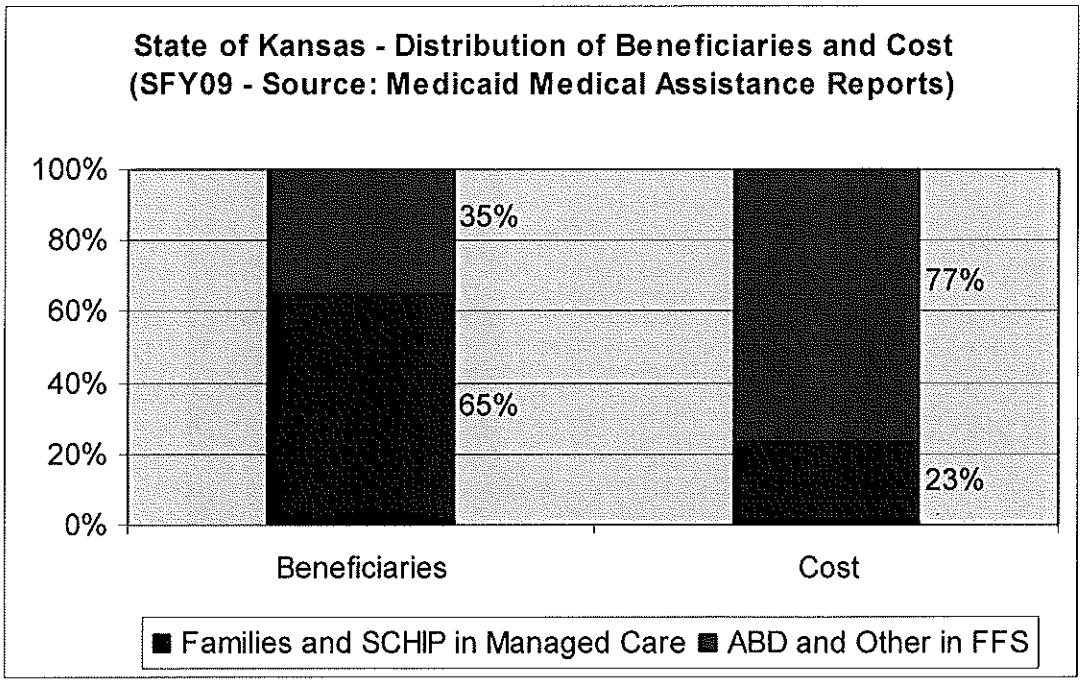

Evidence of Kansas' ability to limit program cost increases utilizing capitated managed care contracts to manage Medical services for TAF/PLE/CHIP Medicaid populations is also illustrated in KHPA's recent budget analysis. The report provided total expenditures and counts of beneficiaries for state fiscal years 2005 through 2009. The Kansas Medicaid Expenditures report shows general revenue funds expended per TAF/PLE/CHIP beneficiaries enrolled in managed care increased only 3.8% during the period from 7/1/06 to 7/1/09 compared to other Medicaid Populations managed by Kansas FFS programs which increased 10% over the same time frame.




There are inherent savings in the actuarial rate setting process as well. Under a fully capitated environment, it is reasonable to expect that Medicaid MCOs can generally achieve cost savings estimates in the range of 3% - 7% relative to FFS programs.[14] Based on current MCO capitation payments, such a range equates to savings ranging from $11 to $27 million annually.

Further, CMFHP provides affordability in the overall cost to Kansas, while maintaining low administrative overhead. For example, according to a Milliman study based on CY 2008 MCO reported financial data for 141 Medicaid MCOs domiciled in 31 states, the average administrative cost ratio was 11.8%. Based on financial data filed with the Kansas Department of Insurance, CMFHP's administrative cost ratio for CY 2008 was 5.3% and the combined average for the two Kansas MCOs was 5.7%.

It is also important to point out the distribution of beneficiaries and the cost for those receiving medical assistance benefits in Kansas. For example, as you can see from the chart below, families and kids in managed care represent 65% of the total population, however, that group only represents 23% of the overall costs. The ABD and other FFS populations represent only 35% of the population, but more than 77% of the total medical assistance expenditures in Kansas. Since such a small portion of the population accounts for such a large portion of the cost, it makes sense to focus resources on managing those population costs.




Pharmacy Program: Cost Savings Realized and Potential Opportunities

CMFHP contracts with a Pharmacy Benefit Management (PBM) company, Caremark CVS, to establish and maintain a Preferred Drug List (PDL) and extensive pharmacy network, maximizing opportunities to manage pharmacy utilization and cost. Caremark CVS partners with CMFHP to routinely analyze member and prescriber utilization patterns to identify areas where interventions, such as changes to the PDL, generic mandates, member lock-ins, and provider profiling would enhance efficiency and improve quality. Overall drug spend trends for CMFHP have remained below national averages. The 2009 drug spend trend was 5%.

In addition, there are other **potential cost savings opportunities** on the horizon through MCOs. Although we receive modest rebates as part of our PBM contract, historically Medicaid MCOs have not been able to access the same drug manufacturing rebates that are available to FFS Medicaid programs. The recent health reform legislation introduced and, as of December 24, 2009, passed in both houses of Congress includes the provisions of the *Medicaid Prescription Drug Rebate Equalization Act of 2009*. This legislation allows Medicaid MCOs to receive the same drug rebates that are currently available to FFS Medicaid. The savings generated from this legislation will directly benefit the state Medicaid program. The cumulative savings for Kansas for the period FY 2010-2019 are projected to be $56 million or roughly $5 to $7 million per year.

## III. Improved Health Care Access & Outcomes

By contracting with MCOs like CMFHP, Kansas has the ability to harness the expertise of private companies that focus on providing comprehensive health care benefits and increased access to specialized services. As in other Medicaid managed care programs, KHPA measures CMFHP on specific performance measures. KHPA recently

provided the following list of some of those measures to the Kansas Joint Committee on Health Policy Oversight:[15]

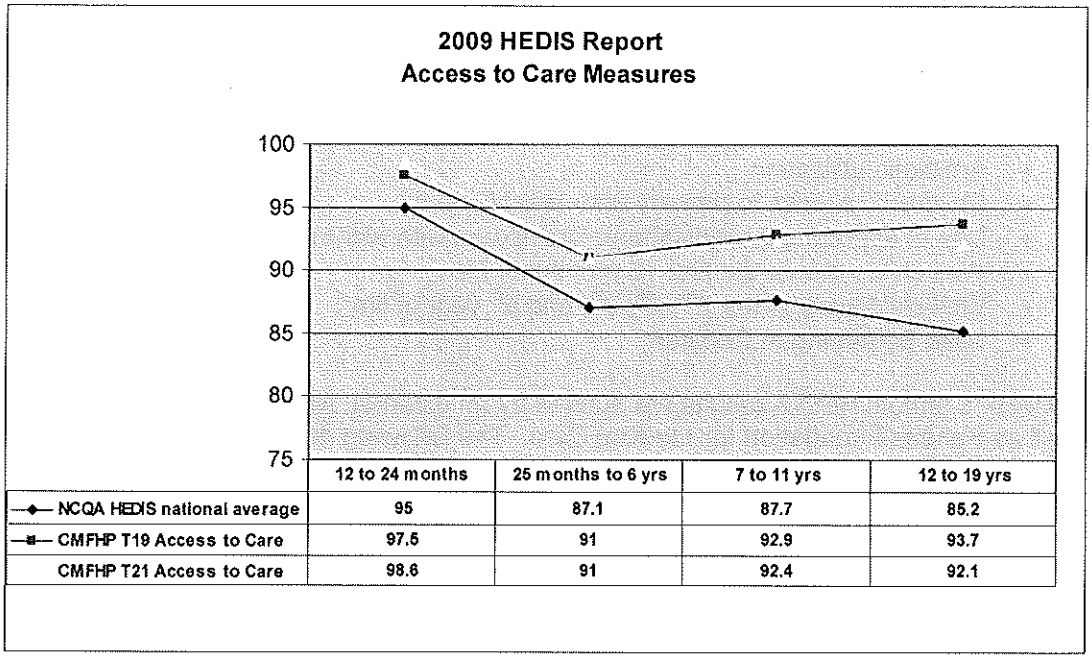
- Adult access to preventive/ambulatory health services
- Comprehensive diabetes care (HbA1c tests)
- Prenatal and postpartum care (prenatal visits)
- Antibiotic utilization
- Children's access to primary care practitioners
- Use of appropriate medications for children with asthma
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th year of life
- Lead Screening in Children

CMFHP's annual HEDIS results are audited by an external, NCQA-accredited entity, as well as Kansas Foundation for Medical Care. The following are highlights of the 2009 report, based on 2008 data.

**Strengths: (areas where CMFHP performed at or above HEDIS Medicaid Mean)**

- Use of Appropriate Medications for People with Asthma
- Adult Access to Primary Care Providers
- Children's Access to Primary Care Providers
- Well child in the First 15 Months of Life – Title 21 population
- Adolescent Well Care – Title 19 population
- Timeliness of Prenatal Care
- Postpartum Care

As referenced above, CMFHP's 2009 HEDIS results for measuring Access to Services demonstrated performance that exceeds the HEDIS national average for children accessing healthcare services. Results ranged from a low of 91% to a high of 98.6%. See chart below.




| | 12 to 24 months | 25 months to 6 yrs | 7 to 11 yrs | 12 to 19 yrs |
|---|---|---|---|---|
| NCQA HEDIS national average | 95 | 87.1 | 87.7 | 85.2 |
| CMFHP T19 Access to Care | 97.5 | 91 | 92.9 | 93.7 |
| CMFHP T21 Access to Care | 98.6 | 91 | 92.4 | 92.1 |

CMFHP believes that it is able to achieve such outstanding access measures due in large part to its extensive primary care network. CMFHP's network is comprised of more than 4,600 contracted providers of which, 1,552 are Primary Care Providers (PCPs). Further, in the urban area of the State, 55% of Kansas licensed PCPs participate in our network. CMFHP's participation rate in rural areas is 99% which equates to an overall participation rate of 72%.

As part of our continuous efforts at improving quality of care and ensuring positive outcomes for CMFHP's members, we also are able to identify areas for improvement via the HEDIS review process. The list below represents a few of those opportunities.

**Areas of Opportunity for Performance Improvement Initiatives in 2010: (areas where CMFHP performed below HEDIS Medicaid Mean)**

- Comprehensive Diabetes Care Measures
- Cervical Cancer Screening
- Chlamydia Screening

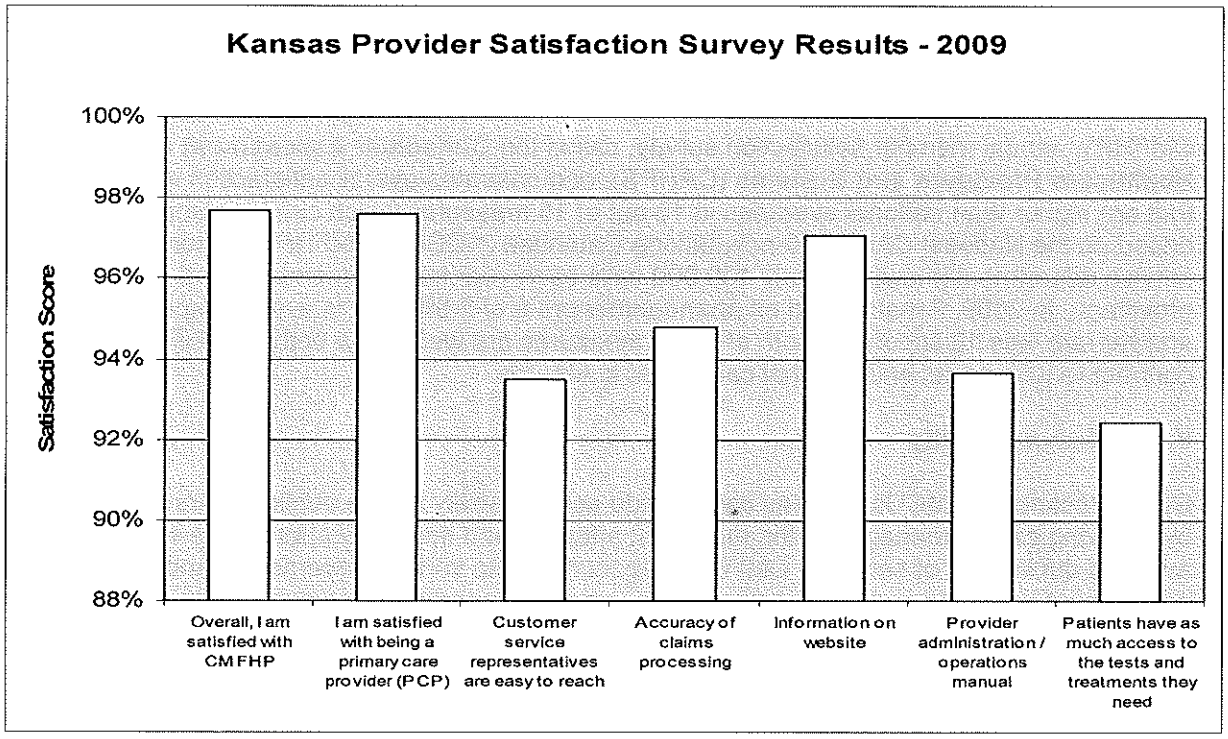
In order to fulfill contract obligations with the State, as well as provide high quality care at the right time for the right cost, MCOs must invest in infrastructure including extensive clinical resources. These resources include nurse care managers, disease management educators, and health improvement coaches. Investments in these resources allow MCOs to focus on long term cost containment strategies instead of short term cost cutting measures.

## IV. Providing Superior Provider & Customer Satisfaction

Provider Satisfaction Results

KHPA's awarding of contracts to two new MCOs in late 2006 was not completed without some anxiety from Kansas providers. The Kansas Medical Society (KMS) raised concerns regarding whether the new MCOs would have adequate networks in place to provide the same level of access to Kansas HealthWave & Medicaid beneficiaries.[16] CMFHP and Unicare worked closely with KHPA, KMS and the Kansas Hospital Association (KHA) to ensure a smooth transition process occurred. According to KHPA a relatively seamless transition did indeed occur after the contracts were awarded.[17] Further, neither KMS nor KHA cited any problems in their dealings with CMFHP.[18] CMFHP believes our positive performance with our provider partners is reflected in the satisfaction survey results referenced below.

The Kansas Foundation for Medical Care (KFMC), at the request of the State of Kansas, has conducted a provider satisfaction survey for the last two years to determine the level of provider satisfaction with CMFHP, UniCare and HealthConnect Kansas (HCK). For the last two years, CMFHP has received the highest overall plan satisfaction rate. In 2009 the overall provider satisfaction rate with CMFHP was 98%. Some of the categories measured by the survey are highlighted on the following graph.



As noted in the chart below, in 8 of 9 composite measures of KFMC's survey, the total MCO score was higher than the HCK program. See the chart below.

| | | Provider Survey Rates - 2009[19] | | | | | |
|---|---|---|---|---|---|---|---|
| Composite Category (1) | Survey Questions | CMFHP | UniCare | MCO Total (3) | HCK | MCO B(W) HCK | CMFHP B(W) HCK |
| **Satisfaction** | 1-3 | 96.2% | 93.3% | 95.3% | 93.4% | 1.9% | 2.8% |
| **Access to Services/Treatments** | 4-7 | 85.4% | 85.5% | 85.5% | 84.1% | 1.3% | 1.3% |
| **Customer Service** | 8-9 | 90.6% | 85.4% | 88.9% | 78.9% | 10.1% | 11.7% |
| **Non-Pharmacy Prior Authorizations** | 10-11 | 83.4% | 75.3% | 80.8% | 77.9% | 2.9% | 5.5% |
| **Finance Issues** | 12-15 | 94.0% | 91.0% | 93.0% | 91.1% | 1.9% | 2.9% |
| **Pharmacy and Drug Benefits (4)** | 16-21 | 83.6% | 72.9% | 80.2% | 76.6% | 3.6% | 7.1% |
| **Resources** | 22-23 | 95.4% | 90.5% | 93.8% | 92.6% | 1.2% | 2.8% |
| **Program Services/Education** | 24-28 | 74.7% | 73.0% | 74.2% | 69.3% | 4.9% | 5.4% |
| **Quality Improvement (2)** | 29a-31c | 38.9% | 35.4% | 37.7% | 42.6% | 4.9% | 3.8% |

Note (1): The Provider Survey Rates presented are simple average composite scores of the questions noted in Col B.
Note (2): For the Quality Improvement survey composite, a lower score is better.
Note (3): The MCO Total Rate is a member month based weighted average of CMFHP and UniCare (67.9% / 32.1%).
Note (4): Question 21 regarding e-prescribing is excluded from the ratings due to its non-comparability.

Customer Satisfaction Results

CMFHP's annual member satisfaction survey, called the **Consumer Assessment of Healthcare Providers and Systems** (CAHPS), demonstrates overall satisfaction levels that are higher than national averages in 13 out of 15 measures which can be compared based on the National CAHPS Benchmarking Database (NCBD). CMFHP's customer service department answers nearly 100,000 calls each year from its members and providers. In 2009, it maintained an abandonment rate of 2.5% and its average speed of answer rate was 12 seconds. Both of these measures are well below both CMFHP contract requirements and national call center standards.

## V. Accountability

By contracting with MCOs, Kansas can provide accountability for the public dollars spent by ensuring care is managed in the most cost effective and medically appropriate setting avoiding duplication of services. CMFHP is accountable to various government and non-government agencies and participates in regulatory and contractual compliance audits throughout each year. The following table lists those accountabilities:

| Agency | Nature of Oversight | Frequency |
|---|---|---|
| Centers for Medicare and Medicaid Services (CMS) | CMS Managed Care Regulations | Bi-annually |
| Healthcaredata.com | HEDIS Auditor | Annually |
| The Joint Commission | Asthma Program Certification | Ongoing data submission and intra-cycle reviews; tri-annual recertification |
| Kansas Dept. of Insurance | U/R Certification | Annual renewal |
| Kansas Foundation for Medical Care (KFMC) | HEDIS, CAHPS, Performance Improvement Projects, Encounter Data, and RFP Compliance | Annually and ongoing |
| Kansas Health Policy Authority (KHPA) | State Contract Compliance | State contract includes 312 "Must" and 645 "Shall" requirements which CMFHP meets to be fully compliant. Also, an annual audit of those requirements; quarterly reporting obligations; policy review and approval. |
| NCQA | Utilization Management, Quality Management, Credentialing, Member Rights | Application for accreditation has been submitted; accreditation survey expected in June 2011 |
| Qualis | CAHPS Auditor | Annually |
| United States Office of Civil Rights | HIPAA Privacy, Security, Confidentiality | Ad hoc reporting obligation |

## VI. Recommendations

1. The cost for the ABD population covered by the Kansas HealthWave FFS program is disproportionately and significantly higher than the families covered by the MCOs (as illustrated on page 6). This is true both in cost per individual and in overall cost. This is certainly not an unusual or surprising issue in state Medicaid programs. We recommend that KHPA dedicate its available resources to focus on and evaluate all possible options to address this most significant cost driver for the Kansas Medicaid program. These options may include but not be limited to implementing additional care management tools and/or vendor contracts targeted to high cost/high use individuals, consider an enhanced PCCM program targeted to more urban areas and/or multi-specialty physician groups, and consider the use of capitated managed care on a pilot or comprehensive basis.

2. If KHPA is concerned about excessive net income/profits within its current managed care contracts, we recommend it consider modifying existing and future contracts and contract requirements such that the state would only contract with not-for-profit MCOs and/or include provisions to establish Medical Loss Ratio (MLR) requirements. We recommend that these provisions provide that if the MCO has a MLR less than the agreed upon target that the excess funds be returned in full to the state. We believe this approach is reasonable for a mature program like HealthWave, is appropriate for a taxpayer funded program, is currently in place in other states, exists in various forms of the current national health reform proposals, and would provide the state with the necessary assurance they desire that the net income/profits from the contracted Medicaid MCOs are reasonable.

3. We recommend that KHPA move forward to work with the Kansas Legislature regarding modifications to K.S.A. 40-3202(s) to extend the 1% HMO privilege tax to the currently excluded Medicaid HMOs, as discussed in our meeting on October 9, 2009. As previously indicated, CMFHP and Unicare have agreed to work with KHPA and the Kansas legislature on the revision of the statute which could generate an additional $5.85 million annually in federal matching funds.[20]

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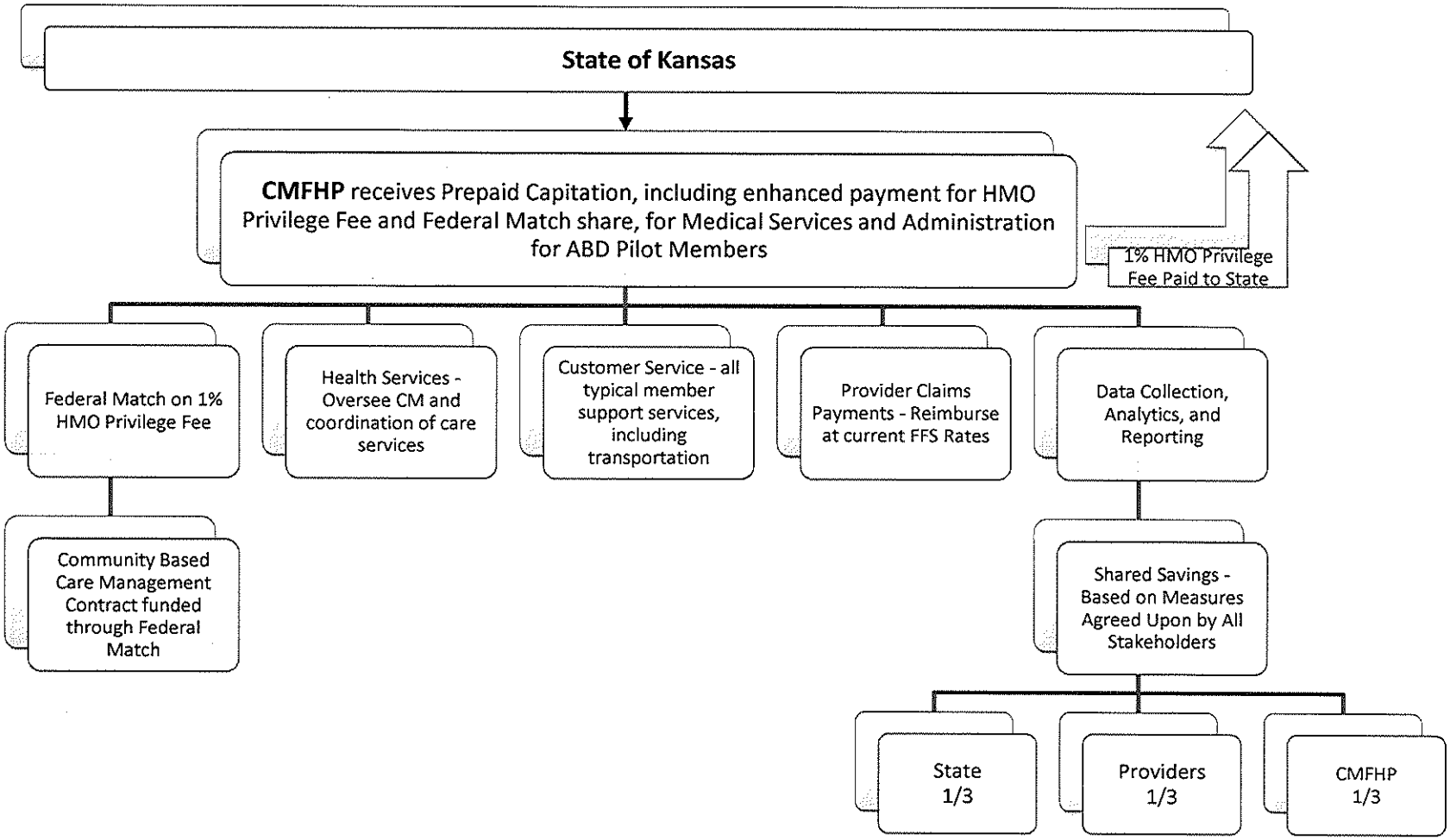
[1] KHPA Testimony by Dr. Andrew Allison, KHPA Acting Executive Director, provided to the Joint Committee on Health Policy Oversight; December 17, 2009.
[2] KHPA 2008 Medicaid Transformation Plan – Chapter 12: HealthConnect Kansas Program Review, January 2009; page 171.
[3] Minutes from the Joint Committee on Health Policy Oversight Hearing, October 16, 2006; p. 5.
[4] KHPA Enrollment Report, October 21, 2010.
[5] Managed Care Cost Savings – A Synthesis of 24 Studies; The Lewin Group; July 2004, updated March 2009; pages 1-2.
[6] See 2009 Children's Mercy Family Health Partners' Program and Operations Overview, pages 7-14.
[7] Id. at pages 57-58.
[8] Id. at pages 28-37.
[9] Id. at pages 38, 57-58, 65.
[10] Id. at pages 16-19; 40-52.
[11] Id. at pages 7-14, 38-52.
[12] Id. at pages 55-59.
[13] Managed Care Cost Avoidance Model, Missouri Department of Social Services, MO HealthNet Division; Mercer Consulting Services, January 29, 2010.
[14] Milliman, Inc. Letter dated December 29, 2009 from Scott A. Weltz, FSA, MAAA to Suzie Dunaway, CMFHP's Chief Financial Officer.
[15] KHPA Testimony by Dr. Andrew Allison, KHPA Acting Executive Director, provided to the Joint Committee on Health Policy Oversight; December 17, 2009.
[16] Kansas Medical Society, e-Connect Newsletter; October 20, 2006. See web address here - http://www.khpa.ks.gov/healthwave/download/KMSeconnect10-20-06.pdf
[17] Ranney, Dave (Feb. 20, 2007). Health Policy Authority declares its managed care transition a success; http://www.khi.org/news/2007/feb/20/health-policy-authority-declares-its-managed-care/
[18] Ranney, Dave (May 7, 2007) Unicare performance improving, say doctors and hospitals; http://www.khi.org/news/2007/may/07/unicare-performance-improving-say-doctors-and/
[19] Provider Satisfaction Survey 2009 – Survey administered on behalf of KHPA by the Kansas Foundation for Medical Care
[20] Assumes a more conservative FMAP rate of 60% which is lower than the current match rate in Kansas.

Appendix B

# ABD Pilot in Kansas – Sedgwick County



Appendix C

# SSI Kids Pilot in Johnson/Wyandotte Counties